Code Sets Road Map

First Determination: Do you have to comply with the HIPAA Rule on Code Sets?

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Department of Health and Human Services published the final rule regarding the electronic transactions in the Federal Register on August 17, 2000. The rule applies to all health information transmitted or received using electronic media. Electronic media includes Internet (wide-open), Extranet (using Internet technology that links a business with information that is only accessible to collaborating parties), leased lines, dial-up lines, private networks, and magnetic tape, disk, or compact disk media that are used to transport information from one physical location to another. Other examples of electronic transmission are: computer to computer, person to computer, online interactive transmission such as browser to server, fax-back, telephone voice response, and HTML interactions.

Health information means any information, whether oral or recorded in any form or medium, that is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual.

Only certain types of organizations are required to comply with the Transaction rule. They are referred to as "covered entities". Whenever a covered entity conducts a transaction, it must use the appropriate medical and administrative code sets in the code sets rule.

Does your entity have health information transmitted or received electronically?

- ❑ Yes
- ❑ No

Are you a covered entity?

The law applies to all covered entities who provide health care, health plans, healthcare clearinghouse services, and who transmit health information using electronic media in connection with healthcare transactions.

A healthcare transaction means the exchange of information between two parties to carry out financial or administrative activities related to health care. This includes health care claims or encounter information; health care payment and remittance advice; coordination of benefits; health care claim status, enrollment, disenrollment and premium payments; referral certification and authorization; first report of injury; health claims attachments; and other transactions that the HHS Secretary may prescribe by regulation.

Does your entity exchange information related to health care for financial or administrative activities?

- ❑ Yes
- ❑ No

Health plan means an individual or group plan that provides or pays for the cost of medical care. This includes governmentally funded programs, especially the components of the government agency administering the program. Also included are group health plans, health insurance issuers, HMOs, Part A or Part B of Medicare programs, the Medicaid program, issuers of Medicare supplemental policies, issuers of long-term care policies. The following are excluded: a nursing home fixed-indemnity policy, and employee welfare benefit plans, health care programs for active military personnel, veterans health care programs, the Civilian Health and Medical Program of Uniformed Services (CHAMPUS), the Indian Health Service program, the Federal Employees Health Benefit Program, an approved state child health plan, the Medicare + Choice program, and any other individual or group plan, or combination of individual or group plans, that provides or pays for the cost of medical care.

Health care clearinghouse means a public or private entity that either translates the nonstandard formats received from another entity into the standard formats, or translates the standard formats received from another entity into the nonstandard formats. This includes (but is not limited to) entities such as billing services, re-pricing companies, community health management information systems, community health information systems, and value-added networks.

Health care provider means a provider of services, a provider of medical or other health services and any other person or organization who furnishes, bills, or is paid for health care in the normal course of business. Health care means care, services, or supplies furnished to an individual and related to the health of the individual. Health care includes preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, counseling, service or procedure with respect to the physical or mental condition, or functional status, of an individual or affecting the structure or function of the body.

Are you a:

- ❑ Health plan
- ❑ Health care clearinghouse
- ❑ Health care provider

If you are one of the above choices, you are a covered entity.

Is there any other issue as to whether or not you are a covered entity?

Explain: _____

Second Determination: What is a code set?

A code set is any set of codes used for coding medical diagnoses, procedures, drugs, medical supplies, and non-physician medical services.

This document will cover the medical code sets.

This document will not cover the administrative code sets that are standardized in the transaction sets, such as tables of terms, codes for types of providers, types of services, claim status, adjustment reason codes, codes for race/ethnicity, gender, ZIP Codes, etc. All proprietary administrative codes need to be replaced by HIPAA mandated national standard administrative code sets.

Remember this is a 'one time system conversion' with long term benefits for the national standard medical code sets and the national standard administrative code sets.

What are the medical codes sets required by HIPAA?

Medical code sets for health care services are required for data elements in the administrative and financial health care transaction standards adopted under HIPAA for diagnoses, procedures, and drugs. This was done in effort to standardize the code sets for process efficiency, reduction of costs in duplication of many code sets, and improvement of health care quality. All other proprietary-medical codes needs to be replaced by (or cross-walked to) HIPAA mandated national medical code sets.

The five medical code sets related to health care that are already in use by most health care providers, health plans, and health care clearinghouses and are identified in the final rules for HIPAA standards. DHHS did not establish a common schedule for implementing new versions of all HIPPA medical code sets, because some of the medical code sets are updated annually and some are updated more frequently. The organizations that maintain the medical code sets will specify their own update schedules.

ICD-9-CM International Classification of Diseases, 9th Revision, Clinical Modification

This is a standard code set for classifying diagnoses in any health care setting and procedures performed on inpatients. This code set is published and maintained by National Center for Health Statistics (NCHS) for U.S. usage.

Diagnoses: Classifying diagnoses from Volumes 1 & 2 include diseases, injuries, impairments, health problems and their manifestations, and causes of injury, disease, or other health problems. These codes are displayed as alpha and numeric in 5 digits, with an extra space for a decimal point. The ICD-9-CM diagnosis codes are divided into the following categories: infectious & parasitic diseases, neoplasms, endocrine, nutritional, & metabolic diseases and immunity disorders, diseases of blood and blood-forming organs, mental disorders, nervous system & sense organs, circulatory system, respiratory system, digestive system, genitourinary system, pregnancy, childbirth, and puerperium, skin & subcutaneous tissue, musculoskeletal system & connective tissue, congenital anomalies, conditions originating in perinatal period, symptoms, signs, & ill-defined conditions, injuries, poisonings, drugs, and factors influencing health status and contact with health services.

Format: 999.99; V99.99; E999.9

Update: Annually - October by NCHS.

Changes: Published in the NCHS, CMS, and AHA websites. The annual updates to the ICD-9-CM require public comment and notification. Questions about the ICD-9-CM diagnosis codes can be directed to the ICD-9-CM Coordination and Maintenance Committee by e-mail (dfp4@cdc.gov or alb8@cdc.gov) or fax by 301-458-4022. All requests and comments received by April and December of previous year will be considered for October 1 of the following year by the Four Cooperating Parties (CMS, American Hospital Association, AHIMA, and NCHS).

For more information regarding history and ICD-9-CM **diagnosis** code (Volume 1 and 2) changes, see:
www.cdc.gov/nchs/icd9.htm
U.S. DHHS, Centers for Disease Control and Prevention,
National Center for Health Statistics,
ICD-9-CM Coordination and Maintenance Committee
6525 Belcrest Road, Room 1100
Hyattsville, MD 20782.

Procedures: Classifying procedures from Volume 3 include preventive procedures, diagnostic procedures, and procedures for treating or managing the diseases, injuries, and impairments. These codes are displayed as numeric in 4 digits, with an extra space for a decimal point. The ICD-9-CM procedure codes are divided into the following categories: nervous system, endocrine system, eye, ear, nose, mouth & pharynx, respiratory system, cardiovascular system, hemic and lymphatic system, urinary system, male genital system, female genital system, obstetric procedures, musculoskeletal system, integumentary system, and miscellaneous diagnostic and therapeutic procedures.

Format: 99.99

Update: Annually - October by CMS.

Changes: Published in the CMS website. The annual updates to the ICD-9-CM require public comment and notification. Questions about the ICD-9-CM procedure codes can be directed to the ICD-9-CM Coordination and Maintenance Committee by e-mail (pbrooks@cms.hhs.gov, afagan@cms.hhs.gov, or agruber@cms.hhs.gov) or fax by 410-786-5318. All requests and comments received by April and December of previous year will be considered for October 1 of the following year by the Four Cooperating Parties (CMS, American Hospital Association, AHIMA, and NCHS).

For more information regarding history and ICD-9-CM **procedure** code (Volume 3) changes, see:
Http://www.cms.hhs.gov/paymentsystems/icd9
410-786-5318 or 410-786-5662 or 410-786-1542
Centers for Medicare and Medicaid Services
CMM, HAPG, Division of Acute Care
Mail Stop C4-09-06
7500 Security Boulevard
Baltimore, MD 21244-1850

For the ICD-9-CM official version, it is available on CD-Rom from the Government Printing Office (GPO) at 202-512-1800 or fax at 202-512-2250. The CD-ROM contains the ICD-9-CM classification system and coding guidelines.

Do not confuse this ICD-9-CM code set with the ICD-9, a generic version developed by the World Health Organization for vital statistics coding. ICD-9 only has the diagnoses and causes of injuries (Volumes 1 & 2) and it does not have the 5th digit as displayed in the ICD-9-CM. The ICD-9 does not have procedures.

Other versions are also available from several not-for-profit and private vendors.

CPT-4 Current Procedural Terminology-4th Edition

This is a standard code set for classifying physician services and other health care services in non-inpatient settings. These services include: physician services, physical and occupational therapy services, radiologic procedures, clinical laboratory tests, other medical diagnostic procedures, hearing and vision services, transportation services including ambulance. This system is also commonly known as Level I CPT Codes.

This code set is published and maintained by American Medical Association (AMA). These codes are displayed as numeric in 5 digits, with no decimal point. The CPT procedure codes are divided into six major sections (evaluation and management or E/M, anesthesiology, surgery, radiology, pathology and laboratory, and medicine). It also contains 2-numeric digit modifiers that identify circumstances that alter or enhance the description of a procedure. I can go into more details on the modifiers, if you desired (Modifiers may be used to indicate: a service or procedure having both a professional and technical component; a service or procedure was performed by more than one physician and/in more than one location; a service or procedure having been increased or decreased; only part of a service was performed; an adjunctive service was performed; a bilateral procedure was performed; a service or procedure was provided more than once; unusual events occurred.) Too wordy???

Format: 99999 (plus 99 for modifiers)

Update: Annually – January by AMA's CPT Editorial Panel.

Changes: The annual updates to the CPT require public comment and notification. Questions about the CPT codes can be directed to the CPT Editorial Panel by telephone 312-464-4723 or fax at 312-464-5762. All requests received on a quarterly basis before each meeting will be considered for the following January 1st by the CPT Editorial Panel (AMA, Blue Cross/Blue Shield Association, American Hospital Association, Health Insurance Association of America, and co-chair of Health Care Professionals Advisor). Be sure to use the request form at the website listed below.

For more information, see
Http://www.ama-assn.org/cpt
(800) 621-8335 or (312) 464-4723
CPT Editorial Research and Development
American Medical Association,
515 North State Street,
Chicago, IL 60610

Other versions are also available from several not-for-profit and private vendors.

HCPCS Healthcare Common Procedure Coding System

This is a standard code set for classifying medical supplies, orthotic and prosthetic devices, durable medical equipment (DME), certain outpatient procedures, other items used in health care services, and drugs and biologics for non-pharmacy claims. This system is also commonly known as Level II HCPCS National Codes.

"Local" codes assigned by individual Medicare carriers are eliminated. However, there is a National Medicaid EDI HIPAA (NMEH) Workgroup dedicated to look at the local codes (Level III). They have done a tremendous amount of work in bringing in all local codes used by Medicaid agencies and consolidate them down to a concise list. The local codes have been used to describe new procedures that are not yet available in Level I or II. In many cases, new local codes were requested and granted by CMS as Level II HCPCS Temporary codes. Be sure to keep an eye on the implementation date for using these codes.

The Level II HCPCS code set is published and maintained by Centers for Medicare and Medicaid Services (CMS). Every code is displayed with a single alpha letter (A through V), followed by 4 numeric digits. It also contains 2 alpha-numeric digits (AA-VP) modifiers to identify circumstances that alter or enhance the description of a service or supply.

The HCPCS codes are divided into the following categories: transportation services, medical and surgical supplies, administrative, miscellaneous and investigational, enteral and parental therapies, dental procedures, durable medical equipment, temporary procedures/professional services, drugs, orthotics devices, prosthetics and its implants, medical services, pathological and laboratory services, radiological services, vision services, hearing services, and speech-language pathology services.

Format: X9999 (plus XX for modifiers)

Update: Annually - January by CMS

Changes: The annual updates to the HCPCS require public comment and notification. Questions about the HCPCS codes can be directed to the HCPCS Coordinator by e-mail (hcpcs@cms.hhs.gov) or telephone 410-786-5323. All requests received by April 1st will be considered for the following January 1st by the HCPCS National Panel (Blue Cross/Blue Shield Association, Centers for Medicare and Medicaid Services, Health Insurance Association of America). Be sure to use the request form at the website listed below.

HCPCS Healthcare Common Procedure Coding System (continued)

For more information, see
Http://www.cms.hhs.gov/medicare/hcpcs.htm
HCPCS National Editorial Panel
7500 Security Boulevard C5-08-27
Baltimore, MD 21244-1850

CDT-4 Current Dental Terminology, or Code on Dental Procedures and Nomenclature, or The Dental Code, Fourth Edition (

This is standard code for classifying dental services in dental settings.

This code set is published and maintained by American Dental Association (ADA) Council on Dental Benefit Programs. Every code is displayed as alpha and numeric in 5 digits, with the first digit as "D" and there is no decimal point. The CDT procedure codes are divided into 12 categories of services (diagnostic, preventive, restorative, endodontics, periodontics, removal prosthodontics, maxillofacial prosthetics, implant services, fixed prosthodontics, oral surgery, orthodontics, and adjunctive general services).

Fomat: D9999

Update: Annually - January by ADA.

Changes: The annual updates to the CDT require public comment and notification. Questions about the CDT codes can be directed to the ADA staff by e-mail (dentalcode@ada.org) or telephone 312-440-2753. All requests received by October 1st will be considered for the next version published in two years by January 1st. For example, CDT-5 draft will review all requests submitted by October 2003 and will be considered for its final version (CDT-5) for January 2005. Be sure to use the request form at the website listed below.

For more information, see:
Http://www.ada.org/prof/prac/manage/benefits/codecommittee.html
(800) 947-4746 or 800-621-8099, extension 2753
Council on Dental Benefit Programs
American Dental Association
211 East Chicago Avenue
Chicago, Illinois 60611

NDC National Drug Codes

This is standard code for classifying drugs and biologics by retail pharmacies. Each drug product listed under Section 510 of the Federal Food, Drug, and Cosmetic Act, enacted in February 1973.

This code set is published and maintained by U.S. Department of Health and Human Services, in collaboration with drug manufacturers.

Every code is displayed as numeric in 11 digits, with no decimal point. The NDC identifies drugs down to the manufacturer, product name, and package size. The NDC are updated on a continuous basis throughout the year, whereas the J codes in HCPCS system is assigned on annual basis. In the past, many providers were currently forced to maintain both "J" HCPCS codes and NDC codes to provide data to different insurers. It was with hope to reduce the workload of providers who had to utilize two drug coding systems. With the revised change in the transaction rule, the NDC codes are to be reported on the pharmacy transactions and the HCPCS J codes are to be reported on the 837 Health Care Claims: Professional for non-pharmacy claims.

Do not confuse this code set with the FDA's regulation of 10 digits coding structure.

All NDC numbers must be 11 digits long. NDCs printed on packages often have fewer than 11 digits, with hyphens (-) separating the number into three segments. For a complete 11-digit number, the first segment must have 5 digits, the second segment must have 4 digits, and the third segment must have 2 digits. Leading zeros are added left-justified, wherever they are needed to complete a segment with the correct number of digits.

Package Number	Zero Fill (5-4-2)	11-digit NDC
1234-1234-12	(01234-1234-12)	01234123412
12345-123-12	(12345-0123-12)	12345012312
2-22-2	(00002-0022-02)	00002002202

Format: 99999999999

Update: Quarterly within 5 working days after the end of March, June, September, and December by CDER Advisory Committee.

Changes: Questions about the NDC codes can be directed to the FDA staff by e-mail (drls@cder.fda.gov) or telephone 301-827-5467. The changes will take effect after the end of March, June, September, and December by the CDER.

NDC National Drug Codes (continued)

For more information, see:
Http://www.fda.gov/cder/ndc
Food and Drug Administration
Information Management Team HFD-095
5600 Fishers Land
Rockville, Maryland 20857
301-827-6500 or fax 301- 443-1726.

There are three more code sets that may be proposed in the future. No decisions have been made regarding changes in the code set standards. Those who produce and process health transactions should anticipate these changes and build in system flexibility to allow them to implement different code set formats. Any recommendation regarding the implementation of new standards will require a new Notice of Proposed Rule Making and it will be published in the Federal Register.

ICD-10-CM International Classification of Diseases, 10th Revision, Clinical Modification

ICD-10 was developed by the World Health Organization and has been implemented in 30 countries in 37 languages to report the mortality diagnosis data. ICD-10 in vital statistics was implemented in U.S. for mortality reporting on January 1, 1999.

Due to the ICD-9-CM classification's age (20 plus years) and content, it is no longer clinically accurate. ICD-9-CM update process cannot keep pace with changes. It is not comparable to the state/national mortality data or the international data.

Since U.S. cannot use the ICD-10 system because it lacks the morbidity data, NCHS developed a detailed draft version for clinical modification (ICD-10-CM). It expanded to 2,033 categories, which contained 855 more categories than the ICD-9-CM. This expansion will provide distinctions for ambulatory and managed care encounters, new concepts, new emerging diseases, and more recent medical knowledge.

The development of this project included consultation with physician groups (dermatology, neurology, psychiatry, orthopedics, pediatrics, and obstetrics & gynecology), professional organizations (ADA, AHA, AHIMA, ANA, NACHRI), and other users of ICD-9-CM (federal agencies, workers compensation, epidemiologists, researchers). ICD-10-CM will provide more relevant data for patient safety (medical errors), surveillance & prevention activities, outcome research, and increased sensitivity when making refinements in applications such as grouping and reimbursement methodologies.

The format will contain alpha and numeric values, with 6 digits and another space for decimal point. It has harmonization with DSM-IV descriptions, neoplasms and morphology codes for cancer registry programs, and NANDA nursing classification. It reflects currant usage of medical terminology and has greater flexibility to add new codes.

Format: A00.000-Z99.999

ICD-10-CM International Classification of Diseases, 10th Revision, Clinical Modification (continued)

For more information, see:
Http://www.cdc.gov/nchs/icd9.htm

There are adobe format files for the pre-release draft of ICD-10-CM codes (including crosswalks to ICD-9-CM) in the NCHS web site. The codes in ICD-10-CM are NOT currently valid for any purposes or uses. The adoption of ICD-10-CM requires regulatory action.

The National Committee on Vital and Health Statistics (NCVHS) conducted public hearings. The results supported the urgent need to begin the process to move to new and better standards for diagnoses and procedures; the replacement of the diagnosis and procedure classifications to occur simultaneously; and the need to do in-depth impact analysis and cost estimates of such implementations. For more information, Http://ncvhs.hhs.gov

ICD-10-PCS International Classification of Diseases, 10th Revision, Procedural Classification System

Centers for Medicare and Medicaid Services (CMS) recognized the need to develop a replacement of the 23-year-old procedure section of ICD-9-CM. The framework for this new system was to come from the National Committee on Vital and Health Statistics (NCVHS), which defined the essential objectives for the procedural system as completeness, expandability, multiaxial, and standardized terminology.

The following NCVHS requirements are:

Completeness in that all substantially different procedures will have unique codes.
Expandability in that it allows annual code additions, such as new medical procedures.
Multiaxial in that each code has a standard meaning within and across procedure sections.
Standardized terminology in that it avoids confusion and multiple meanings for the same term.

CMS developed a draft of ICD-10-PCS, to meet the requirements of NCVHS. Historically, CMS had planned to implement this in 2001, but this date has been moved back several times due to the passage of HIPAA. The HIPAA coding standards cannot be changed unless the CMS goes through the official HIPAA process, which begins with NCVHS hearings and its recommendation to the Secretary of Health and Human Services.

This format will contain alpha and numeric values, with 7 digits and no decimal point. The 7 characters will have numeric values of 0-9, and alpha values of 1-H, J-N, and P-Z. Each character has 34 values.

1st character: sections (i.e. medical & surgical, nuclear medicine, rehab, measurement & monitoring, osteopathic, laboratory, mental health, etc)
2nd character: body system where the procedure is performed (i.e. Hepatobiliary System and Pancreas; Heart and Great Vessels)
3rd character: type of procedure (i.e. incision, excision, bypass, dilation, drainage, reattachment, removal, repair, reposition, etc)
4th character: specific body part (i.e. right lobe of liver; one coronary artery)
5th character: specific approach (i.e. open, percutaneous, endoscopic, etc)
6th character: device used in the procedure (i.e. drainage device, autograft, radioactive element, etc)
7th character: qualifier for extra information (i.e. diagnostic or not)

It will provide complete, accurate, and consistent information for improving the quality of patient care.

ICD-10-PCS International Classification of Diseases, 10th Revision, Procedural Classification System (continued)

Format: XXXXXXX

For more information, see:
Http://cms.hhs.gov/providers/pufdownload/icd10.asp

The adoption of ICD-10-PCS requires regulatory action.

Currently the NCVHS has not been able to make any recommendations on replacing the ICD-9-CM's procedure part. The staff from CMS and NCHS is drafting a language for the Notice of Proposed Rulemaking, which would propose ICD-10-CM and ICD-10-PCS, in hopes that the NCVHS would be able to make a recommendation. It is hoped to replace the ICD-9-CM system with the ICD-10-CM for diagnosis codes and ICD-10-PCS for procedure code reporting for all hospital inpatient services.

LOINC Logical Observation Identifiers, Names and Codes

Historically, the Health Level Seven (HL7) is a standard organization that works exclusively in the healthcare industry and desires to simplify the implementation of message-base data interfaces between healthcare information systems. Level Seven is the seven highest level of International Standards Organization open systems communication model. The seventh level is concerned with things like security checks, participant identification, availability checks, exchange mechanism negotiations, and most important, data exchange structuring.

The HL7 covers messages that exchange information in: patient demographics, patient insurance and guarantor, patient charges and accounting, encounters including registration, admission, discharge, and transfer, orders for clinical services (tests, procedures, pharmacy, dietary, and supplies), clinical observations, observation reporting, including test results, synchronization of master files between systems, medical record document management, scheduling of patient appointments and resources, patient referrals, and patient care and problem-oriented records.

The X12 American National Standards Institute (ANSI) adopted the HL7 messages, which included the LOINC codes for the proposed healthcare claims attachments (275 transaction set). Regenstrief Institute and the Logical Observation Identifiers Names and Codes Committee developed a draft of LOINC codes. These LOINC codes will describe clinical observations made by the EMS ambulance transport team, observations noted about the patient's response to rehabilitation treatments, observation results of medication, dosage, timing, and route, observation of lab results, findings from various clinical reports (x-rays, EKGs, consultations, ….), and observation symptoms noted in the Emergency Department.

In the web site, ……wpc-edi.org …..you can download the 277/275 pdfs that will provide the following…….(not done)

LOINC Code Booklets

• LOINC Code Tables for the HL7 "Additional Information to Support a Healthcare Claim or Encounter" Message: Ambulance
• LOINC Code Tables for the HL7 "Additional Information to Support a Healthcare Claim or Encounter" Message: Rehabilitation Services
• LOINC Code Tables for the HL7 "Additional Information to Support a Healthcare Claim or Encounter" Message: Medications
• LOINC Code Tables for the HL7 "Additional Information to Support a Healthcare Claim or Encounter" Message: Laboratory Results
• LOINC Code Tables for the HL7 "Additional Information to Support a Healthcare Claim or Encounter" Message: Clinical Reports
• LOINC Code Tables for the HL7 "Additional Information to Support a Healthcare Claim or Encounter" Message: Emergency Department

Format:

For more information, see:

Http://www.hl7.org

Http://www**. (give LOINC web site)**

Third Determination: Which code set applies to you?

❑ ICD-9-CM	Diagnoses (all health care settings)
❑ ICD-9-CM	Inpatient Procedures
❑ CPT-4	Outpatient Procedures, Physician services, Other health-related services
❑ HCPCS	Medical supplies, DME, orthotics, prosthetics, devices, drugs, other items used in health care services, and certain outpatient procedures.
❑ CDT	Dental services in dental settings.
❑ NDC	Drug and biologics codes

Do you have the tools to review the selected code sets?

For more detailed information, you can review Appendix C "External Code Sources" and you can access the websites mentioned in this document for ICD-9-CM, CPT, HCPCS, CDT, and NDC codes.

What are the steps for cross-walking your code set to the HIPAA standard code set?

The **first** step is to compare all the codes you currently use. You can use a data file layout from your current system as a start.

The **second** step is to determine which of the new code sets you will need to receive or send, such as the ICD-9-CM diagnosis, CPT-4 procedures, ICD-9-CM inpatient procedures, NDC drug codes, CDT dental services. Make a note of any current code sets that will continue to be used by entities that have applied for a HIPAA compliance extension, such as the DSM-IV, SNOMED, etc.

The **third** step is to match your current codes to the HIPAA national code sets. In each code set, list the requirements, such as definitions, field length, data type (alpha or numeric or both), code value, edits, any special notes, your edit rules. Cross-referencing these codes is a tedious process.

The **fourth** step is to make a list of all the discrepancies between your current code sets and the new HIPAA standard code sets. This will be become a "gap analysis" because it details all the gaps between the old coding system and the new coding system. You will probably find, for instance that there are several pieces of information that are required by HIPAA that you do not now collect. The gap analysis will also identify the problems that may be encountered with the new format in terms of field lengths, data types, code values, and definitions. Determine whether your entity can live with it or not, and what changes need to be made in your business processes. If not, see the question on "Do you have an issue with a data element, in that it does not fit with your business?"

The **fifth** step is to analyze the impacts that these code set changes will have on your workflow and processing procedures. Educate your staff and other parties (or trading partners) on the new data formats for your business processes.

These steps will help you oversee the translator or clearinghouse service and make sure it is cross-walking to what you want. Data can be stored in any format on your system as long as it can be translated into the standard transaction when required.

Is there a cross-walk of the proprietary code sets to the HIPAA code sets?

No. However, you may want to check with your business partners or trading partners and see if they have other crosswalks of one code set to another code set. For example, do they have a crosswalk of DSM-4 to ICD-9-CM diagnosis codes, or NDC to HCPCS codes? If so, compare to see if it is a one-to-one match, or one-to-many match, or many-to-one match. Determine which crosswalk you can use for your business process.

What are the impacts if you do or do not use the standard code sets?

When HIPAA code sets become effective, all health plans will have to receive and process all standard codes.

Health care organizations that do not follow official coding guidelines are required to:
1) modify their systems, 2) accept all standardized codes in the standard code set, and 3) use a translation system to process the standard transactions.

The HIPAA law gives the Secretary of U.S. DHHS the authority to impose monetary penalties for failure to comply with a standard. The Secretary is required by statute to impose penalties of not more than $100 per violation on any person or entity that fails to comply with a standard, except that the total amount imposed on any one person or entity in each calendar year may not exceed $25,000 for violations of one requirement. Enforcement procedures will be published by Centers for Medicare and Medicaid Services (CMS) in future regulations. However, CMS announced in the modified transaction rule (dated February 2003) that it will take into account the numerous obstacles and will work with covered entities through corrective action plans that show a reasonable effort for achieving one-time compliance, rather than penalize their noncompliance. It is critical that you contact all of your trading partners regarding your approach to compliance.

What are the challenges with implementing the standard code sets?

Data exchange between the various health care organizations requires accuracy and efficiency of the HIPAA national standard code sets.

Payers are required to have the capability to receive and process all standard code sets.

Health plans will need to modify their systems to process the transactions with the national standard code sets.

Staff needs to become familiar with business processes that are transformed and streamlined for HIPAA, standard code sets, and transaction sets.

Do you have an issue with a code set? Do you know what to do if the code set's definition, format, or codes will not work for your business needs? How do you share your concerns, internally, statewide, or nationally? Do you have solutions to the resolved issues?

When reviewing the data segment within the transaction set, a data element may list an external source for you to contact. For more detailed information, you can review Appendix C "External Code Sources". You can contact the external source and state your issue and business case. The source may ask you to complete its form requesting review and change. It will discuss the pros and cons of the issue, determine if a solution or your solution would be good to implement across the nation, and then vote. The issue will go to the next level of review by one of six Designated Standard Maintenance Organizations (DSMOs). You may want to appear before the DSMO and state your reasons for supporting the change. If the change is approved, it will be posted in the Federal Register.

As with any HIPAA standard, it will take two years to implement an approved change. An exception may be allowed for the testing of proposed modifications to the standards. An entity wishing to test a different standard must apply for an exception to test the new standard. Instructions for applications are published in the final transaction rule.

Further, the Secretary of U.S. DHHS may modify a standard one year after it was adopted, but not more than once every 12 months. If the Secretary modifies a standard, the implementation date may be no earlier than 180 days (or 6 months) following the adoption of the modification. The implementation date will be determined by DHHS, taking into account the time needed to comply given the nature and extent of the modification. DHHS may extend the time for compliance for small health plans. Standard modifications will be published as regulations in the Federal Register.

The charge for the six DSMOs is to maintain the standards. The six DSMOs are:

1) American National Standard Institute (ANSI) who chartered the Accredited Standards Committee (ASC) X12 to develop the uniform standards for electronic data interchange (EDI)), http://www.x12.org/
2) Dental Content Committee of American Dental Association, http://www.ada.org/goto/decc
3) Health Level 7 (HL7) (the highest application level of this organization's communication model), http://www.hl7.org/
4) National Council for Prescription Drug Program (NCPDP), http://www.ncpdp.org/
5) National Uniform Billing Committee (NUBC), and http://www.nubc.org/
6) National Uniform Claim Committee (NUCC). http://www.nucc.org/

These six DSMOs are to consult with the four Data Content Committees (DCCs) for advice and consideration of a new or modified data element standard. The four DCCs are:

1) Workgroup for Electronic Data Interchange (WEDI), http://www.wedi.org/

2) American Dental Association (ADA), http://www.ada.org/goto/decc
3) NUBC, and http://www.nubc.org/
4) NUCC. http://www.nucc.org/

You can join any one of the data standard organizations. As a benefit, you can submit an issue and follow its progress early on. You can also review issues that other entities submitted, provide comments, and vote on these issues. You can review and vote on new proposed standards prior to their implementation.

For more information on the change request process, see:
Http://www.hipaa-dsmo.org/

Why do we have to test? What is involved?

Testing is basically a test to determine if we can read each other's code sets. It is like asking, "Can you read my code set? Can I read your code set?" Enter N/A if you or your trading partners are not using or will not be using that HIPAA standard code set.

HIPAA Standard Code Set	Ready Date for Testing	Ready Date for Production
ICD-9-CM Diagnosis		
ICD-9-CM Inpatient Procedures		
CPT-4 Ambulatory Procedures		
CDT-4 Dental Services		
HCPCS Devices & Ambulatory Services		
HCPCS Local Codes adoption as Level II HCPCS codes		
NDC Prescription Drug codes for retail pharmacy transactions		
ICD-10-CM Diagnoses		
ICD-10-PCS Inpatient Procedures		
LOINC for claims attachments		

You need to communicate with each other (internally, and externally such as providers, internal state departments, business associates, clearinghouses, and any other trading partners). These code sets must be specified in your trading partner agreement.

Do you know what a trading partner agreement is?

Trading Partner Agreement mean an agreement related to the exchange of information in electronic transactions. It may specify the duties, responsibilities of each party in conducting a standard transaction. The specific requirements and specifications must be specified in the trading partner agreement.

It is appropriate and prudent for payers to have trading partner agreements that go with the standard Implementation Guides. This is because there are two levels of scrutiny that all electronic transactions must go through.

First is standards compliance. These requirements MUST be completely described in the Implementation Guides for the standards, and NOT modified by specific trading partners.

Second is the specific processing, or adjudication, of the transactions in each trading partner's individual system. Since this will vary from site to site (e.g., payer to payer), additional documentation which gives information regarding the processing, or adjudication, will prove helpful to each site's trading partners (e.g., providers), and will simplify implementation process.

It is important that these trading partner agreements do NOT:
· Modify the definition, condition, or use of a data element or segment in the standard Implementation Guide
· Add any additional data elements or segments to this Implementation Guide
· Utilize any code or data values which are not valid in this Implementation Guide
· Change the meaning or intent of this Implementation Guide

These types of companion documents should exist solely for the purpose of clarification, and should not be required for acceptance of a transaction as valid. Trading partner agreements are not allowed to set data specifications that conflict with the HIPAA implementation.

Do you want an example of a basic Trading Partner Agreement Form?

- ❑ Yes
- ❑ No

Do you have an example of your own Trading Partner Agreement form? Will you share?

- ❑ Yes
- ❑ No

Fourth Determination: Do you have enough time and resources to accomplish all of the above?

- Build in a timeline
- Develop a team of at least 1-2 people
- Identify code sets currently in use
- Identify information systems (each system may require more than one change, one change may impact other systems)
- Educate staff
- Determine future relationships and communicate with trading partners
- Determine methods to secure partner relationships (every relationship is different)
- Evaluate products/tools to help you with inbound and outbound data transmission
- Funding
- Develop a trading partner agreement form, tailored to the relationship you are dealing with (not a one-size-fits-all model).
- Testing, testing, testing, and testing until all parties are satisfied.
- Complete a full HIPAA impact analysis in order to make educated and strategic decisions